Georgia Department of Community Health

IF YOU AND ALL COVERED DEPENDENTS ARE U.S. CITIZENS OR LAWFUL RESIDENTS OF THE U.S. DO NOT COMPLETE THIS FORM

INSTRUCTIONS: If you or any of your covered dependents are not U.S. Citizens/Lawful Residents of the U.S., complete this form and return immediately to SHBP even if you are making your election online. You may return in the enclosed envelope or mail to SHBP, P.O. Box 1990, Atlanta, GA 30301-1990. If we do not receive this form by November 10, 2011, you are certifying that all covered members of your family are either U.S. citizens or lawfully present in the U.S. Returning this questionnaire will have no impact on your coverage under SHBP. This information is needed to qualify for federal funds under the Patient Protection and Affordable Care Act.

RETIREE PERSONAL INFORMATION:

Retiree First Name: _____ Last Name: _____ Social Security No. _____

Street: _____ Apt. # _____ City: _____ State _____

Country _____ Postal Code _____ Telephone #: _____

ENROLLEE INFORMATION: List each enrollee below for whom the statement is true.

First Name	Last Name	Date of Birth	Relationship - (self, child, spouse)	SSN or Other Identifier	Certification
					This person is NOT a U.S. Citizen and is NOT lawfully residing in the U.S.
					This person is NOT a U.S. Citizen and is NOT lawfully residing in the U.S.
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					This person is NOT a U.S. Citizen and is NOT lawfully residing in the U.S.

I certify that the information listed above is correct to the best of my knowledge.

Signature _____ **Date** _____